



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

AMERIMED INTERNATIONAL INC
PO BOX 261353
PLANO TEXAS 75026

DWC Claim #:

Injured Employee:

Date of Injury:

Employer Name:

Insurance Carrier #:

Respondent Name

AMERICAN HOME ASSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-05-1753-01

MFDR Date Received

NOVEMBER 4, 2004

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "Fair and Reasonable Usual and Customary"

Amount in Dispute: \$2,795.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...This is a request for purchase of a device combining IF and NMES. Because it is a combination device, it does not fall under any specific Medicare fee schedule. The price is about \$2,500. In the attached materials is a chart for the Medicare rental rates for a TENS and NMES. Because IF is to be used in a facility, in the acute stage and only as an adjunct to therapeutic exercises, there is not rental or purchase rate for IF devices. Because NMES is for temporary use, only a rental rate (\$89/month) is listed. All medical care under the Texas Workers' Compensation Act must be evaluated for cost effectiveness. TEX. LABOR CODE § 413.011. There is no justification for the cost of this combined unit compared to its two separate functions, even assuming the combination of these therapies in one unit or the simultaneous use of these two modalities is medical justified (which they are not)..."

Response Submitted by: Flahive, Ogden & Latson, PO Drawer 13367, Austin, TX 78711

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
April 14, 2004	E1399 – Purchase of an Interferential Stimulator	\$2,795.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.301 sets out the procedures for retrospective review of medical bills.

3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. This request for medical fee dispute resolution was received by the Division on November 4, 2004. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on November 10, 2004 to send additional documentation relevant to the fee dispute as set forth in the rule.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - N, 1 – Payment for this charge is not recommended without documentation of cost. (X348)
 - * - Previously requested information/documentation has not been received. (X022)
 - * - Payment for this charge is not recommended without documentation of cost. (X023)
 - * - Our position remains the same; if you disagree with our decision please contract the TWCC Medical Dispute Resolution. (X394)

Findings

1. The insurance carrier, in their position summary, raises the issue of medical necessity. However, the requestor has listed a preauthorization number, HDI # 015393101 in box 23 of the CMS-1500. In accordance with 28 Texas Administrative Code §133.301(a) the insurance carrier shall retrospectively review all complete medical bills and pay for or deny payment for medical benefits in accordance with the Act, rules, and the appropriate Commission fee and treatment guidelines. The insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment and/or services for which the health care provider has obtained preauthorization. Therefore, the insurance carrier's denial of medical necessity stated in their position summary is not supported.
2. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iv).
5. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
 - The requestor's position statement / rationale for increased reimbursement from the *Table of Disputed Services* asserts that "Fair and Reasonable Usual and Customary."
 - The requestor does not discuss or explain how "Fair and Reasonable Usual and Customary" supports the requestor's position that the amount sought is a fair and reasonable reimbursement for the services in this dispute.
 - In support of the requested reimbursement, the requestor submitted redacted explanations of benefits, and selected portions of EOBs, from various sample insurance carriers. However, the requestor did not discuss or explain how the sample EOBs support the requestor's position that additional payment is due. Review of the submitted documentation finds that the requestor did not establish that the sample EOBs are for services that are substantially similar to the services in dispute. The carriers' reimbursement methodologies are not described on the EOBs. Nor did the requestor explain or discuss the sample carriers' methodologies or how the payment amount was determined for each sample EOB. The requestor did not discuss whether such payment was typical for such services or for the services in dispute.

- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 18, 2013 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.